

# The Tooth Booth Group Limited

# Tooth Booth Needham Market

## Inspection Report

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Date of inspection visit: 17 January 2017  
Date of publication: 21/02/2017

### Overall summary

We carried out an announced comprehensive inspection on 17 January 2017 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well led?

#### **Our findings were:**

##### **Are services safe?**

We found that this practice was not providing safe care in accordance with the relevant regulations.

##### **Are services effective?**

We found that this practice was providing effective care in accordance with the relevant regulations.

##### **Are services caring?**

We found that this practice was providing caring services in accordance with the relevant regulations.

##### **Are services responsive?**

We found that this practice was providing responsive care in accordance with the relevant regulations.

##### **Are services well led?**

We found that this practice was not providing well-led care in accordance with the relevant regulations.

#### **Background**

Tooth Booth-Needham Market is one of eight practices owned by Tooth Booth Group Limited. It was established in 2011 and provides mostly NHS services to about 6000 patients. In addition to general dental services, it provides domiciliary dental services to about 3000 patients across mid Suffolk.

The team consists of two permanent dentists (both of whom undertake the domiciliary work), two permanent nurses, a practice manager and a receptionist. They are supported by three additional part-time locum dentists and two locum nurses.

The practice opens from 8.30am to 6pm on Mondays, Wednesdays and Fridays; from 8.30am to 8pm on a Tuesday and Thursday, and on Saturdays from 8.30 am to 1pm. The domiciliary service operates from 9am to 5pm Monday to Fridays.

One of the practice's owners is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

# Summary of findings

Before the inspection we sent comment cards to the practice for patients to complete to tell us about their experience of the practice. We received feedback from 10 patients via the cards and spoke with two patients during our inspection.

## **Our key findings were:**

- The practice offered extensive opening hours both during the week, at weekends and patients were able to access appointments at times that suited them. Emergency slots were available each day for patients requiring urgent treatment.
- Patients received clear explanations about their proposed treatment and were actively involved in making decisions about it. They were treated in a way that they liked by staff.
- Staff had received safeguarding training and took good action to protect vulnerable patients when needed.
- Patients' needs were assessed and care was planned and delivered in line with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and other published guidance.
- The practice relied heavily on locum dentists and nurses to ensure the service could be provided.
- The practice's sharps handling procedures and protocols were not in compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

- Some of the practice's infection control procedures and protocols did not meet guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.

## **We identified regulations that were not being met and the provider must:**

- Ensure effective systems and processes are established to assess and monitor the service against the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and national guidance relevant to dental practice. This includes the recording of untoward events, the management of sharps, the recruitment of staff and the control of infection.

## **There were areas where the provider could make improvements and should:**

- Carry a TREM card (traffic emergency card) in vehicles when transporting oxygen cylinders.
- Review the systems for monitoring and tracking prescription pads in the practice
- Review the storage of dental care records to ensure they are held securely.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

We found that this practice was not providing safe care in accordance with the relevant regulations. The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

The practice had effective arrangements for essential areas such as clinical waste, the management of medical emergencies and dental radiography (X-rays). Staff had received safeguarding training and were aware of their responsibilities regarding the protection children and vulnerable adults. However, untoward events were not always recorded or analysed to prevent their reoccurrence; infection control and sharps' management did not meet national guidelines and put staff and patients at unnecessary risk, and recruitment procedures needed to be more robust to ensure only suitable staff worked at the practice.

Requirements notice



### Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

Consultations were carried out in line with best practice guidance from the National Institute for Health and Care Excellence (NICE) and the Faculty of General Dental Practice Guidelines. Patients received a comprehensive assessment of their dental needs including taking a medical history. Treatment risks, benefits, and options were explained to patients in a way they understood and staff followed appropriate guidelines for obtaining patient consent. Patients were referred to other services as needed.

The staff were able to access professional training and development appropriate to their roles; although they did not have development plans in place and not all received appropriate appraisal. The practice had struggled to recruit staff and relied heavily on locum dentists and nurses to deliver the service.

No action



### Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

We collected 10 completed patient comment cards and obtained the views of a further two patients on the day of our visit. We also spoke with the manager of four care homes that the domiciliary service visited. These provided a positive view of the service and the staff. Patients commented on the cleanliness of the practice, and described staff as empathetic, caring and that they explained their treatment well.

No action



# Summary of findings

Staff gave us specific examples where they had gone beyond the call of duty to support patients.

## Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations.

The practice offered extended hour opening and patients could access routine treatment and urgent care when. Appointments were easy to book and patients were able to sign up for text reminders for them. The practice had made good adjustments to accommodate patients with a disability.

There was a complaints system in place which was publicised and accessible to patients, although minor concerns that patients raised were not always recorded appropriately.

No action



## Are services well-led?

We found that this practice was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

The practice had a number of policies and procedures to govern its activity and held regular staff meetings. Patients' feedback was actively sought and used to improve the service. However, we found a number of shortfalls indicating that the practice was not well-led including the recording of untoward events, the management of sharps, the recruitment and development of staff and the control and prevention of infection. We received mixed feedback from staff about the quality senior leadership within the Tooth Booth Group.

Requirements notice



# Tooth Booth Needham Market

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection was carried out on 17 January 2017 by a CQC inspector who was supported by a specialist dental adviser. During the inspection we spoke with two dentists, the practice manager, two dental nurses and the receptionist. We reviewed policies, procedures and other

documents relating to the management of the service. We received feedback from 12 patients about the quality of the service, and spoke to the managers of four care homes that the domiciliary service visited.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

These questions therefore formed the framework for the areas we looked at during the inspection.

# Are services safe?

## Our findings

### Reporting, learning and improvement from incidents

We found that some staff's knowledge of the requirement to record and report accidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) was limited and the practice manager was not aware of the types of accidents and incidents that should be reported. There was no significant event policy within the practice and staff we spoke with were unaware of the practice's reporting procedures. Staff told us of two untoward incidents including a nurse who fainted in a very warm treatment room and another nurse who had sustained a sharps' injury whilst handling a matrix band. We could find no record of these events and no evidence that learning from them had been shared across the staff team. One of the nurses who worked on the practice's domiciliary care service told us she worked with patients with dementia who sometimes became aggressive whilst undergoing treatment. Once again, we found no evidence that these incidents had been recorded and formally shared with staff.

National patient safety alerts were sent to the practice manager by the provider's head office who then actioned them if required. The practice manager told us she put all relevant alerts on display in the kitchen to make staff aware of them. Staff were aware of recent alerts affecting dental practice.

The British Endodontic Society uses quality guidance from the European Society of Endodontology recommending the use of rubber dams for endodontic (root canal) treatment. A rubber dam is a thin sheet of rubber used by dentists to isolate the tooth being treated and to protect patients from inhaling or swallowing debris or small instruments used during root canal work. The provider had a policy in place about the use of rubber dams and dentists we spoke with confirmed they used them routinely.

### Reliable safety systems and processes (including safeguarding)

Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies and guidance were easily accessible to all staff and clearly outlined whom to contact for further guidance if they had concerns about a patient's welfare. Records

showed that all staff had received safeguarding training for both vulnerable adults and children, although there was no appointed named lead within the practice. Staff we spoke with understood the importance of safeguarding issues and the practice manager told us that one of the dentists had reported her concerns about a care home she had visited to relevant agencies. We noted comprehensive information about adult and child safeguarding agencies throughout the practice including treatment rooms, the waiting area and the patient's toilet. This demonstrated to us that the practice took the protection of people seriously.

Staff spoke knowledgeably about action they would take following a sharps' injury. We noted that sharps' bin labels had been completed correctly, although they had not been wall mounted to ensure their safety. Dentists used conventional sharps and no risk assessment had been completed for the consideration of moving to safer systems. Staff we spoke with were unaware of recent legislation regarding the management of sharps, and of the need to replace sharps bins after three months, even if not full. The way the nurse described to us how she dismantled matrix bands was very unsafe and posed a significant risk of injury. We noted there had been a recent matrix band injury at the practice, although the accident form for this could not be found during our inspection.

### Medical emergencies

There were arrangements in place to deal with medical emergencies and we found there was ample emergency equipment for both the domiciliary and practice based services. An automated external defibrillator (AED) was available and staff had received training in July 2016 in how to use it. Staff had access to oxygen, along with other related items such as manual breathing aids and portable suction in line with the Resuscitation Council UK guidelines. The practice held training sessions each year for the whole team so that they could maintain their competence in dealing with medical emergencies. However, staff did not regularly rehearse emergency medical simulations so that they could keep their skills up to date. This was particularly important for the domiciliary care service, as the dental nurse told they often arrived at a care home with no staff available and might be unaware where emergency equipment was kept there.

# Are services safe?

The practice held emergency medicines as set out in the British National Formulary guidance for dealing with common medical emergencies in a dental practice. Mercury and bodily spillage kits were also available.

There was daily emergency equipment and medicines checklist available to ensure vehicles used in the domiciliary services were loaded correctly, however we found staff had not always completed this.

## **Staff recruitment**

We checked recruitment records for both permanent and locum staff. We noted that good information was kept about the locum dentists including evidence of their GDC registration, indemnity insurance, hepatitis status, qualifications and Disclosure and Barring Service check, (DBS). The DBS carries out checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they might have contact with children or adults who might be vulnerable. However none of this information was available for the locum nurses to ensure they were suitable to work with patients. We viewed recruitment information for the most recently employed member of staff and found that references had not yet been obtained, despite them working at the practice since September 2016. There was no record of their employment interview to demonstrate it had been conducted fairly.

The provider had a specific employee handbook, which provided staff with good information about their conditions of employment, essential practice policies and various personnel matters. We spoke with one member of staff who told us she had received a good induction to her role and had greatly valued being able to spend a day at the practice prior to her employment to see if she liked it.

## **Monitoring health & safety and responding to risks**

There was a health and safety policy available with a poster in the kitchen, which identified local health and safety representatives. The practice had completed a full health and safety risk assessment in November 2016 that covered a range of potential hazards in the practice including autoclaves, biological agents, display screen equipment and waste disposal. Staff who worked on the domiciliary service told us risk assessments had been completed at each residential care home they visited to identify potential hazards.

A full Legionella risk assessment had been completed for the practice and we noted that all 11 of its recommendations had been implemented. Hot and cold water temperatures were monitored weekly. Dental unit water lines were flushed through each week with a biocide and staff ran the water lines through each day in accordance with national guidance to reduce the risk of legionella bacteria forming.

A fire risk assessment had been completed in December 2016, although this was very basic and had failed to identify a number of hazards we saw such as the storage of oxygen. Firefighting equipment such as extinguishers was regularly tested and full building evacuations completed every six months, although without patients.

There was a control of substances hazardous to health file in place containing chemical safety data sheets for materials used within the practice, including domestic cleaning products. We noted clear signage throughout the practice to indicating fire exits, first aid staff, X-ray usage and where flammable materials were stored to ensure patient and staff safety.

The practice had a business continuity plan to deal with any emergencies that might occur which could disrupt the safe and smooth running of the service. It included essential contact details of staff and relevant utility companies.

## **Infection control**

The practice had undertaken an infection control audit just before our inspection and had scored 97% indicating it met essential quality standards. Prior to this no audits had been completed and staff were unaware that these should be undertaken every six months according to national guidance.

The practice employed an external cleaner who came in daily. We observed that areas of the practice were visibly clean and hygienic, including the waiting area, staff kitchen and toilet. Equipment used to clean different areas of the practice was colour coded, although it was not stored according to recommended guidelines.

We checked the treatment rooms and saw that surfaces including walls, floors and cupboard doors were free from dust and visible dirt. The rooms had sealed flooring and modern sealed work surfaces so they could be cleaned easily. We noted that the ventilation grill in one treatment

# Are services safe?

room was very dirty and dusty, and there was no evidence to show it had ever been cleaned. We found loose and uncovered medical consumables items in treatment room drawers including local anaesthetics and suction tips. These risked becoming contaminated over time.

The practice had a dedicated decontamination room that was mostly set out according to the Department of Health's guidance, Health Technical Memorandum 01- 05 (HTM 01-05), decontamination in primary care dental practices. The process of cleaning, inspection, sterilisation, packaging and storage of instruments followed a well-defined system of zoning from dirty through to clean. Staff manually cleaned instruments under water for the initial cleaning process, and then placed them in an ultra-sonic bath. Instruments were then inspected under an illuminated magnifier and placed in an autoclave (a device for sterilising dental and medical instruments). When the instruments had been sterilized, they were pouched and stored until required. All pouches were dated with an expiry date in accordance with current guidelines. We were shown the systems in place to ensure that the autoclave used in the decontamination process was working effectively. Data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were complete and up to date.

However we noted the following shortfalls which compromised good infection control and prevention:

- The dental nurse did not wear a disposable apron or mask when decontaminating dirty dental instruments, which increased the risk of cross infection.
- The overflow on the hand wash sink in the decontamination room had not been sealed.
- Work surfaces in the decontamination room were split and pieces were missing in two places, making was difficult to clean.
- The daily log to record the water temperature had not been completed since December 2015.
- The cleaning log for the distilled water unit had not been completed since August 2016.
- Instruments were manually cleaned in water without the use of any detergent and in an inadequate depth of water.

- Dental instruments were delivered on a tray liner in the surgery, rather than a sterilised or disposable tray to reduce the risk of cross infection.
- Dental clinicians arrived at the practice already wearing their scrubs for the day, and some wore long sleeves making their hands and arms difficult to clean effectively. Staff working on the domiciliary service did not wear disposable aprons whilst treating patients and then travelled in their uniforms to visit up to 10 patients a day, risking cross contamination.
- The ultrasonic bath had not been validated annually by an engineer as required by HTM 01-05 and there was no temperature control on the bath to ensure the water became hot enough.
- Outgoing and incoming laboratory work was disinfected in the same bath, risking cross infection.
- We noted that the dental nurse's fingernails were long, compromising good hand hygiene.

The segregation and storage of clinical waste for both the practice based and domiciliary service was in line with current guidelines laid down by the Department of Health. Clinical waste was stored outside the practice, although the bin was not secured safely to a wall. The practice used an appropriate contractor to remove clinical waste and waste consignment notices were available for inspection.

## Equipment and medicines

The equipment used for sterilising instruments was checked, maintained and serviced in line with the manufacturer's instructions, although there was no evidence that the ultra-sonic bath had been validated. Other equipment was tested and serviced regularly and we saw maintenance logs and other records that confirmed this. For example, portable appliance testing had been completed in November 2015; the compressor had been serviced in January 2016 and oxygen cylinders in May 2016.

We checked one of the vehicles used for the domiciliary service and noted it displayed the correct warning sticker to indicate that oxygen was carried on board. However, the oxygen cylinder in the van was not stored securely enough to prevent its movement in the event of an accident. A TREM card (traffic emergency card) was not available. This must be carried in the cab of any vehicle that is transporting dangerous goods by road. It contains instructions and information that the driver can refer to in

# Are services safe?

the event of an incident involving the hazardous load. The daily checklist for the vehicle had not always been completed to indicate that all required equipment had been loaded.

Staff told us they had enough equipment for their job and that repairs were undertaken quickly. However, we noted that a hand piece used in the domiciliary service to trim dentures was not fit for purpose. One dentist told us they had been unhappy using the practice's hand held X-ray unit until it could be verified as safe to use, with the consequence that x-rays had not been taken during domiciliary visits by either dentist for 3 years. We spoke to the registered manager about this who told us he was in the process of liaising with the radiation protection advisor to resolve the situation. Another member of staff told us that the ventilation system in one treatment room did not work well, making it too hot to work in comfortably during summer months.

We noted a camera and a sign in reception stating that CCTV was in use at the practice. Although we were told it was not currently in use, there was no information available for patients detailing who had access to the images, how long they would be retained for and how to request access to them in line with guidance from the Information Commissioner's Office, 'In the picture: A data protection code of practice for surveillance cameras and personal information'.

Dentists we spoke with were aware of on-line reporting systems to the British National Formulary and of the yellow

card scheme to report any adverse reactions to medicines. We saw from a sample of dental care records that the batch numbers and expiry dates for local anaesthetics were recorded in patients' clinical notes. Prescription pads were locked away at night for safety but were not logged in and out to ensure none were missing each day. There was no system in place to monitor the prescribing of antimicrobials.

## **Radiography (X-rays)**

We reviewed the practice's radiation protection file that contained the names of the Radiation Protection Supervisors and the Radiation Protection Advisor, and evidence that the Health and Safety Executive had been notified of radiation use. We viewed critical examination and acceptance tests for both X-ray units, although noted that no annual mechanical or electrical testing had been completed for them. Local rules were in place but these were not unit specific

Rectangular collimation was used to confine the scatter of x-ray beams. Training records showed that the dentists had received training for core radiological knowledge under IRMER 2000 Regulations.

One dentist told us they were unhappy to use the practice's hand held X-ray machine until it could be properly verified as fully safe.

Regular radiographic audits were completed for the dentists and we saw evidence that the results had been analysed and discussed with clinicians.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Monitoring and improving outcomes for patients

Patients who completed our comment cards told us they were happy with their treatments. One patient described it as prompt, efficient and effective.

During our visit we found that the care and treatment of patients was planned and delivered in a way that ensured their safety and welfare. People's dental records were detailed and clearly outlined the treatment provided, the assessments undertaken and the advice given to them. Our discussions with the dentists showed that they were aware of, and worked to, guidelines from National Institute for Health and Care Excellence (NICE) and the Faculty of General Dental Practice (FGDP) about best practice in care and treatment. Dental care records we viewed evidenced clearly that NICE guidance was followed for patients' recall frequency and that that routine dental examinations for gum disease and oral cancer had taken place. Dental decay risk assessments had been completed for patients.

We saw a range of clinical audits that the practice carried out to help them monitor the effectiveness of the service. These included clinical record keeping, dental radiographs and infection control.

### Health promotion & prevention

A number of oral health care products were available for sale to patients on site including interdental brushes, toothpaste and mouthwash. The dentists told us patients were given advice about dental hygiene, tobacco and alcohol consumption. However, no leaflets were available about smoking cessation for patients and staff were unaware of local services that they could refer patients to.

The practice's domiciliary service was commissioned to provide 107 oral health care sessions and the registered manager told us the dentists regularly provided advice on denture care and tooth brushing techniques to patients, their carers and nursing home staff.

### Staffing

The practice had had great difficulty recruiting staff and was relying heavily on locum dentists and nurses to maintain the service. Although two permanent dentists delivered the domiciliary service, the entire practice based service was staffed by locum dentists, supported by

additional locum nurses. Staff told us that patients sometimes complained about the lack of continuity of dentists because of this. Despite this, staff told us there were enough of them to maintain the smooth running of the practice and that a dental nurse always worked with the dentist. Staff told us they did not feel rushed during appointments and appointment schedules we viewed showed that the practice based dentists saw about 25 patients a day, and the domiciliary dentists saw about 8-10 patients a day.

Files we viewed demonstrated that most staff were appropriately qualified, trained and had current professional validation and indemnity insurance, although this information was missing for the locum dental nurses employed at the practice. The practice had appropriate Employer's Liability in place.

Permanent staff received a yearly appraisal of their performance, where their effectiveness, communication and team working abilities were assessed. It was not clear how the performance of locum nurses was monitored. Staff did not have any specific training in working with people with dementia, despite one nurse telling us that working with patients with dementia could be challenging at times.

### Working with other services

The practice made referrals to other dental professionals when it was unable to provide the necessary treatment themselves and there were clear referral pathways in place. Referrals for suspected malignancy were followed up to ensure they had been received. However, no central log of the referrals made was kept so they could be tracked and patients were not routinely offered a copy of their referral for their information.

The practice's domiciliary service visited a number care homes in the region, and managers of these homes reported good working relationships with the dental staff who provided this service.

### Consent to care and treatment

The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Files we viewed showed that staff had undertaken training in patient consent and the MCA. Dental staff we spoke with had a clear understanding of patient consent issues and the key principles of the Act when

# Are services effective?

(for example, treatment is effective)

dealing with patients who were unable to give informed consent. Both the domiciliary dentist and nurse talked of the importance of actively involving care home staff and relatives to make best interest decision for patients living in a home.

Consent forms were sent out to each domiciliary care patient prior to the dentist visiting and treatment did not

begin until the forms had been completed. The practice manager gave us examples of when the dentist had refused to treat people as consent forms were not in place, and they could not be assured that the patient wanted the treatment.

# Are services caring?

## Our findings

### **Respect, dignity, compassion & empathy**

Before the inspection, we sent comment cards so patients could tell us about their experience of the practice. We collected 10 completed cards that provided a positive view of the practice. Patients told us they were treated in a way that they liked by staff. Staff gave us examples of where they had gone out their way to support patients. For example, one patient had accidentally over paid, so the dentist had delivered the repayment directly to the patients' home. The receptionist told us she regularly helped keep children occupied by reading to them and chatted to older and nervous patients to make them feel comfortable. Care home managers told us they would recommend the service, however one felt that dental staff could communicate more effectively with their residents living with dementia.

The main reception area itself was not particularly private and those waiting could easily overhear conversations between reception staff and patients. However, staff told us

they were careful not to give out patients' personal details when speaking on the phone, they ensured patients' notes were kept face down and that any confidential documents were hidden from view. We noted that patients' notes for the domiciliary service were kept in a separate storage room. They were not stored in lockable, fire proof cabinets to ensure their safety and confidentiality

All consultations were carried out in the privacy of the treatment room and we noted that the door was closed during procedures to protect patients' privacy.

### **Involvement in decisions about care and treatment**

There was good evidence in the dental records we reviewed which demonstrated the inclusion of the patients, family and care home staff where appropriate in decision making processes. People we spoke with also confirmed this and told us the dentist always carefully explained things in a way that they could understand.

The practice did not have any treatment information leaflets available to give patients, although the dentist told us they regularly recommended specific web sites for them.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting patients' needs

The practice had a website that gave patients details of its opening hours, the services it offered, the staff employed and reviews from other patients. The practice offered extensive opening hours during the week and on a Saturday morning, making it easily accessible to patients who could not attend during normal working hours. A SMS text messaging service was available to remind patients of their appointment times.

The practice's answering machine gave details of an emergency out of hours contact telephone number, and details were displayed outside the practice should a patient come when it was closed. Two consultation slots were available each day for any patients requiring urgent treatment.

### Tackling inequity and promoting equality

The practice had undertaken a disability audit of its service in 2016 and offered good access to wheel chair users. There was level access into the premises and a stair lift to the lower reception area and treatment rooms. The toilet was

fully accessible. However, there was no portable hearing loop available despite a number of patients with hearing aids, or easy riser chairs in the waiting area for patients with mobility needs.

### Concerns & complaints

The practice had an appropriate complaints procedure in place that included the timescales within which they would be dealt and other agencies that patients could contact. Information about how raise a complaint was available in the waiting area. Minutes of the staff meeting held in January 2017 showed that staff had discussed the practice's complaints procedure to ensure all were aware of the procedure.

We viewed the practice's comprehensive complaints' folder that contained details of each complaint received, correspondence in relation to it, and any follow up action required. We found the complaints had been managed effectively and empathetically. The practice manager told us that verbal complaints from patients were not recorded centrally. For example, she told us that a number of patients had complained about the high turnover of dentists. Although these concerns had been recorded on patients' individual notes, no central log of them had been kept so that they could be monitored for common themes and patterns.

# Are services well-led?

## Our findings

### Governance arrangements

The registered manager, who was also one of the owners, held overall accountability for the practice. He was not actually based at the practice but the practice manager told us he was easy to contact and available when needed. The practice manager had responsibility for the day-to-day running of the practice and we were shown comprehensive daily, weekly and monthly checklists that she used to ensure the service was running safely and effectively. She told us she regularly met with the other managers of Tooth Booth's practices nationally to share information and discuss best practice across the group. However, we identified a number of shortfalls in the practice's governance arrangements including the recording of untoward events, the management of sharps, the recruitment of staff and the control of infection which impacted on the overall safety of the service.

The practice had a number of policies and procedures in place to guide staff and support the management of the service. These were available both in paper format and on the provider's intranet system and had been reviewed to ensure they were up to date and relevant.

Communication across the practice was structured around a monthly practice meeting. We viewed a sample of minutes from the last year that showed a wide range of relevant topics had been discussed with staff. However only the permanent staff and the locum dentists attended. The two permanent dentists who worked on the domiciliary service were not able to attend as the meetings were held when they were working off site, although minutes of them were available. None of the locum dental nurses attended, despite one of them having worked at the practice for over a year.

The registered manager told us he regularly undertook unannounced visits to the practice and that an internal auditor had been employed who regularly checked the quality of dentists' record keeping and treatment.

Professional registration checks were undertaken each year to ensure dental clinicians continued to be fit to practice. Staff received an appraisal of their performance that

covered their clinical effectiveness, communication skills, working with colleagues and patient consent, although none had professional development plans in place. It was not clear how the locum dental nurses were assessed, as they did not receive any appraisal.

The practice had not completed its annual information governance self-assessment so it was not clear if it was managing patients' information in line with legislation

### Leadership, openness and transparency

Staff reported that the practice manager was supportive, however we received mixed feedback from them about senior leadership within company. They told us that senior managers did not listen to their concerns or suggestions. For example, a request for the ventilation system in one treatment room to be improved to reduce excessive heat had not been met. Staff had also suggested using single use matrix bands following a sharps injury, but we were told they were not allowed to order them.

Staff we spoke with did not have an understanding of their obligations under the duty of candour and the practice did not have a policy in relation to it.

### Practice seeks and acts on feedback from its patients, staff

Patients could leave a review online via the practice website and the practice had introduced the NHS Friends and Family Test as a way for patients to let them know how well they were doing. 31 patients had responded between May and November 2016, 79% of whom would recommend the practice. This figure was low compared to practices of a comparable size. Results from NHS Choices showed the practice had scored two and half out of five stars based on 12 reviews.

The practice also encouraged patients to fill in satisfaction surveys that asked them to comment amongst other things on the friendliness of staff, the wait for an appointment, if charges were explained and the overall quality of care they received. The practice manager told us results were analysed and used to improve the service. For example, patients had feedback that the waiting room became very hot on sunny days; as result, a fan had been purchased to keep it cool.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity                                                                                     | Regulation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | <p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The registered person did not have effective systems in place to ensure that the regulated activities at the Tooth Booth Needham Market were compliant with the requirements of Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>This includes:</p> <ul style="list-style-type: none"><li>• Ensuring infection control practices meet national guidance</li><li>• Ensuring the management of sharps' meets national guidance</li><li>• Ensuring the safe recruitment of staff</li><li>• Ensuring untoward events are recorded and managed to prevent their reoccurrence</li><li>• Ensuring all staff have appraisal and personal development plans</li></ul> <p><b>Regulation 17 (1)</b></p> |